etc.), and they had significant improvements in their quality of life. The other patient showed neither clinical nor image changes.
Conclusions: Palliative RT was effective for patients with relapsed or refractory malignant lymphoma. Improved quality of life is expected for such patients regardless of their limited life expectancy.

EP-1110
Chemo-radiotherapy for patients with H&N cancer: evaluation of acute toxicity based on intensity of supportive care
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Purpose/Objective: Most evaluations of toxicity are based on international toxicity scores. We wanted to retrospectively evaluate other clinical parameters such as hospitalization days, use of opioid drugs, infectious comorbility, chemotherapy dose intensity and RT interruptions.
Materials and Methods: Between September 2004 and June 2010, 64 pts underwent CT-RT for oropharynx cancer stage III-IV. Mean age was 63 years (48-75 y) but only 4 pts. were older than 70 years. Forty-four pts (68,8%) underwent definitive concomitant CT-RT, 10 pts (15,6%) underwent definitive sequential CT-RT, 10 pts (15,6%) underwent postoperative adjuvant concomitant CT-RT. The concomitant treatments were DPP based for 47 pts (87%) (DDP every three weeks, DDP weekly and DDP-5FU in 82,9%, 12,8% and 4,3% respectively) and 7 pts received Cetuximab only. The sequential CT-RT was TPF for 7 pts. and DDP-5FU for 3 pts.. Of patients undergoing definitive CT-RT, 21 pts (38,9%) were treated with IMRT with simultaneous integrated boost to doses of 54-66 Gy in 30 fractions, 14 pts (25,9%) were treated with a simple 3D 3-field technique to a dose of 70 Gy in 35 fractions and 19 pts (35,2%) were treated with an elaborate 3D conformal 5-7-field technique to a dose of 70 Gy in 35 fractions. Post-operative radiotherapy was performed with 3-field 3D-RT to a dose of 63 Gy in 35 fractions.
Results: Sixty-one pts (95,3%) received the planned radiotherapy, 5 pts (7,8%) needed a radiotherapy break for treatment toxicity (less than 1 week) while 3 pts had a definitive interruption of the RT: 2 pts. for a tumor progression and 1 pts. for toxicity at 66 Gy of planned 70 Gy. Results regarding dose intensity of chemotherapy were as follows:

	Median cycles	Mean cycles
DDP every 3 weeks	3 (3)	2.6
DDP(weekly)	4 (7)	4.3
Cetuximab	6 (7)	5.7

Fourteen pts. (21,5%) were hospitalized from the beginning of treatment on patient request and 20 pts (31,2%) were hospitalized during the treatment for deteriorating physical condition. Nineteen pts (29,6%) needed nutritional support (parenteral or enteral nutrition) and the duration of the supplementary nutrition was more than 9 weeks for 9 pts (47,3%). Fifteen pts (23,4%) needed opioid therapy and 19 pts (29,6%) needed codeine-based medication. Thirteen pts. (20,3%) developed a clinical infection with 9 of them presenting with pneumonia. No treatment related deaths occured. Toxicity for patients treated with IMRT was lower than for patients treated with 3D-RT for all analyzed endpoints. These data are, however, clearly biased because when IMRT was clinically established at the department, predominantly young patients with few comorbidities were chosen for IMRT
Conclusions: This analysis provides a different view on acute toxicity of RT-CT for head and neck cancer, providing comprehensive objective data in a large patient cohort. Though the reported toxicity is substantial, almost all treatments could be completed as intended. This emphasizes the importance of appropriate patient selection and intensified supportive care. Analysis of late toxicity and clinical results for this patient cohort is under way.

EP-1111
The role of General Practitioners in supportive care of cancer patients after completion of specialist oncology care
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Purpose/Objective: Cancer patients and their families frequently report that coordination of support services is disjointed and subject to regional variation in New Zealand. They are often confused about who to turn to for care after completion of specialist oncology treatment. It is during this period that issues such as medium to long term side effects of the cancer and its treatments and the need for social and psychological support often become apparent. A recent report compiled for the National Office of the Cancer Society of New Zealand indicates that lack of clarity about the role of GPs in ongoing care contributes significantly to thisissue. Both GPs and oncologists differ in their expectations of the follow up support that GPs should provide for patients and their family after completion of specialist care. This presentation will discuss the GP perspective on the issue.
Materials and Methods: Three semi-structured individual interviews and seven focus groups of five to nine participants were conducted in the lower North Island and lower South Island of NZ. Participants were GPs servicing a mixture of urban, rural and varying socio-economic demographics. Interviews and focus groups were audio recorded and later transcribed. Coding was performed using NVivo9. Data analysis follows a constructivist approach to grounded theory. Peer coding and analysis was used.
Results: Core themes that emerged included: variable standards of communication between GPs and oncologists;a belief that GPs have a significant role to play in the supportive care of patients; comparison with a range of chronic conditions for models to guide the role of GPs in the care for cancer patients; concerns over currency of their oncology knowledge; frustration with barriers to patients accessing GP services; limited awareness of services and information which may be of benefit to patients and discussion around cultural considerations pertinent to the NZ setting.
Conclusions: GPs want to actively engage in supporting patients manage their cancer in the short and long term. GPs share a growing perception of cancer as a chronic condition needing a structured approach to ongoing management. They perceive that this is best achieved through partnerships with oncologists, other health professionals and patients themselves. The next phase of the research aims to establish the perceptions of oncologists to complete the picture and construct viable pathways to improving the overall service to patients.

EP-1112
Low-level laser therapy: a standard of supportive care for induced oral mucositis in head and neck cancer patients?
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Purpose/Objective: Induced oral mucositis (IOM) is still a common and severe acute side-effect of many oncologic treatments, especially in patients treated for head and neck cancer. It may affect quality of life, require supportive care and impact treatment planning and its efficacy. Low-level laser therapy (LLLT) seems to promote pain relief and reduces IOM incidence and severity. It has been recommended for these patients as a treatment option but without any consensus in the LLLT procedure. New recommendations and perspectives for clinical trials will be discussed.
Materials and Methods: Step by step, the efficacy of soft laser in the management of induced oral mucositis has been evaluated during the last two decades. Its effectiveness and level of recommendation got stronger with time. We will report and discuss some major results and the latest recommendations published on this topic.
Results: The major clinical results have been reported and analysed last year in a first meta-analysis. Eleven randomized placebo-controlled trials were selected with a total of 415 patients treated with chemotherapy or radiotherapy for head and neck cancer. The relative risk for developing IOM was significantly reduced after LLLT but only for a dose between 1 to 6 Joules per point. Pain, severity and duration of IOM grade ≥ 2 were also reduced without difference with placebo for possible side-effects. Nine years after the positive results published for patients treated by radiotherapy alone, a new randomized, multicentric, phase III trial for patients treated with new standard treatment, using LLLT in accordance to recent recommendations is ongoing. Seven centers are actually opened for this trial which should include a hundred patients.
Conclusions: The very encouraging results of LLLT in the prevention and treatment of IOM in patients treated by chemotherapy or radiotherapy for advanced head and neck cancer could soon be proposed as a new standard of care, according to the Multinational Association of Supportive Care in Cancer (MASCC) criteria. Modern lasers are less time consuming and extraoral applicators for a possible use by trained paramedical staff could be helpful to complete clinician practice. A preventive dose of 2 J/cm^2 and a curative dose of 4 J/cm^2 if using a red wavelength lasers are now recommended.